		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019471

Facility Name: The Arbor

Address: 535 S. Elm Street (Number) Itasca (City) 60143 (Zip Code)

County: DuPage

Telephone Number: (630) 773-9416 **Fax #** (630) 773-9434

IDPA ID Number: 362848501001

Date of Initial License for Current Owners: 08/06/75

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT		[x] PROPRIETARY		[ ] GOVERNMENTAL	
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[x]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,740	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,395	1,395	8
9	SNF/PED					9
10	ICF	28,366	15,113		43,479	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,366	15,113	1,395	44,874	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.38%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/6/75

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 14 and days of care provided 1,395

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	248,689	30,947	7,777	287,413		287,413		287,413			1
2	Food Purchase		197,591		197,591		197,591		197,591			2
3	Housekeeping		26,190	244,305	270,495		270,495		270,495			3
4	Laundry		6,625		6,625		6,625		6,625			4
5	Heat and Other Utilities			87,694	87,694		87,694		87,694			5
6	Maintenance		10,567	17,406	27,973		27,973	1,748	29,721			6
7	Other (specify):*											7
8	**TOTAL General Services**	248,689	271,920	357,182	877,791		877,791	1,748	879,539			8
	B. Health Care and Programs											
9	Medical Director			4,950	4,950		4,950		4,950			9
10	Nursing and Medical Records	1,932,836	124,094	311,053	2,367,983		2,367,983		2,367,983			10
10a	Therapy			72,296	72,296		72,296		72,296			10a
11	Activities	108,618	3,700	520	112,838		112,838		112,838			11
12	Social Services	39,520		2,888	42,408		42,408		42,408			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,080,974	127,794	391,707	2,600,475		2,600,475		2,600,475			16
	C. General Administration											
17	Administrative	151,267			151,267		151,267		151,267			17
18	Directors Fees			30,000	30,000		30,000		30,000			18
19	Professional Services			53,039	53,039		53,039	(238)	52,801			19
20	Dues, Fees, Subscriptions & Promotions			22,801	22,801		22,801	(1,541)	21,260			20
21	Clerical & General Office Expenses	110,729	25,665	27,368	163,762		163,762	(3,491)	160,271			21
22	Employee Benefits & Payroll Taxes			342,079	342,079		342,079		342,079			22
23	Inservice Training & Education			2,292	2,292		2,292		2,292			23
24	Travel and Seminar			1,421	1,421		1,421		1,421			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			107,584	107,584		107,584		107,584			26
27	Other (specify):*											27
28	**TOTAL General Administration**	261,996	25,665	586,584	874,245		874,245	(5,270)	868,975			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,591,659	425,379	1,335,473	4,352,511		4,352,511	(3,522)	4,348,989			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number The Arbor #0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			20,642	20,642		20,642	119,132	139,774			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,778	4,778		4,778	415,162	419,940			32
33	Real Estate Taxes							54,397	54,397			33
34	Rent-Facility & Grounds			1,074,480	1,074,480		1,074,480	(1,074,480)				34
35	Rent-Equipment & Vehicles			7,968	7,968		7,968		7,968			35
36	Other (specify):* **MIP Insurance**							26,623	26,623			36
37	**TOTAL Ownership**			1,107,868	1,107,868		1,107,868	(459,166)	648,702			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		33,661		33,661		33,661		33,661			39
40	Barber and Beauty Shops			9,142	9,142		9,142		9,142			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			78,840	78,840		78,840		78,840			42
43	Other (specify):* **Nonallowable Costs**			13,407	13,407		13,407	(13,407)				43
44	**TOTAL Special Cost Centers**		33,661	101,389	135,050		135,050	(13,407)	121,643			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,591,659	459,040	2,544,730	5,595,429		5,595,429	(476,095)	5,119,334			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	12,013	30		9
10	Interest and Other Investment Income	(2,778)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,689)	43		19
20	Contributions	(550)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	328	43		24
25	Fund Raising, Advertising and Promotional	(4,598)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,619)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule 5A	(7,394)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (11,287)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(464,808)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (464,808)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (476,095)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

The Arbor of Itasca, Inc.
Provider #0019471
12/31/2002

Schedule 5A

VI. Adjustment Detail
Line 29 - Other Non-allowable Expenses

Description	Amount	Line Reference
To disallow sales & use tax	(970)	43
To disallow PAC contributions	(991)	20
To adjust deferred maintenance	1,748	6
To disallow legal fees	(238)	19
To disallow part A lab expense	(1,348)	43
Offset miscellaneous income	(3,947)	21
To disallow vending machine expense	(3,735)	43
To disallow non-allowable advertising	(250)	20
To disallow non-allowable dues	(300)	20
Related organization's miscellaneous income	2,637	n/a
Total	(7,394)	

SEE ACCOUNTANTS' COMPILATION REPORT

The Arbor

ID# 0019471

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	456	0	0	0	0	0	0	0	0	0	456	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	26,623	0	0	0	0	0	0	0	0	0	26,623	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	27,079	0	0	0	0	0	0	0	0	0	27,079	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	27,079	0	0	0	0	0	0	0	0	0	27,079	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Arbor # 0019471 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	12,013	107,119	0	0	0	0	0	0	0	0	0	119,132	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,778)	417,940	0	0	0	0	0	0	0	0	0	415,162	32
33	Real Estate Taxes	0	54,397	0	0	0	0	0	0	0	0	0	54,397	33
34	Rent-Facility & Grounds	0	(1,074,480)	0	0	0	0	0	0	0	0	0	(1,074,480)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	9,235	(495,024)	0	0	0	0	0	0	0	0	0	(485,789)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(13,128)	5,774	0	0	0	0	0	0	0	0	0	(7,354)	43
44	**TOTAL Special Cost Centers**	(13,128)	5,774	0	0	0	0	0	0	0	0	0	(7,354)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,893)	(462,171)	0	0	0	0	0	0	0	0	0	(466,064)	45

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John Florina Sr	30.00%			Itasca Shelter	Itasca	Lessor
John Florina Jr	10.00%			Care, L.L.C.		
Duane Jacobson	30.00%					
Charles Ricci	30.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Bank charges	$	Itasca Shelter Care, L.L.C.	100.00%	$ 456	$ 456	1
2	V	26	Insurance		Itasca Shelter Care, L.L.C.	100.00%	26,623	26,623	2
3	V	30	Depreciation		Itasca Shelter Care, L.L.C.	100.00%	107,119	107,119	3
4	V	32	Interest		Itasca Shelter Care, L.L.C.	100.00%	417,940	417,940	4
5	V	33	Real estate taxes		Itasca Shelter Care, L.L.C.	100.00%	54,397	54,397	5
6	V	34	Rental income	1,074,480	Itasca Shelter Care, L.L.C.	100.00%		(1,074,480)	6
7	V	43	State replacement taxes		Itasca Shelter Care, L.L.C.	100.00%	5,774	5,774	7
8	V	n/a	Miscellaneous income		Itasca Shelter Care, L.L.C.	100.00%	(2,637)	(2,637)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,074,480			$ 609,672	$ * (464,808)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	John Florina Jr	Admin/Asst. Admin	Administration	10.00	None	40	100.00	Salary	$ 109,100	L17, C1	1
2	Duane Jacobson	Owner	Administration	30.00	None	8	20.00	Director fees	10,000	L18, C3	2
3	Charles Ricci	Owner	Administration	30.00	None	8	20.00	Director fees	10,000	L18, C3	3
4	John Florina, Sr	Owner	Administration	30.00	None	8	20.00	Director fees	10,000	L18, C3	4
5	Barbara Florina	Admin/Accounting	Clerical	0.00	None	6	100.00	Wage	5,690	L21, C1	5
6	Daniel Florina	Contractor	Snow removal	0.00	None	Varied	Varied	Contract	1,125	L6, C3	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 145,915		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8		N/A								8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cambridge		x	Mortgage	$36,889.00	1/31/00	$ 5,089,300	$ 5,008,760	02/01/35	0.0820	$ 411,885	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bloomingdale Bank & Trust		x	Line of credit	int. only	10/28/02	175,000	175,000	Demand	0.0425	4,322	6
7	Itasca Bank & Trust		x	Line of credit	int. only	11/23/02	80,000	80,000	4/11/03	0.0475	456	7
8	Shareholder loans	x		Working capital	none	12/31/02	230,000	230,000	12/31/03	0.0500		8
9	TOTAL Facility Related				$36,889.00		$ 5,574,300	$ 5,493,760			$ 416,663	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			6,055	10
11								Interest income offset			(2,778)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3,277	14
15	TOTALS (line 9+line14)						$ 5,574,300	$ 5,493,760			$ 419,940	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 26,623 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.		$ 54,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2001	$ 54,297	2
3. Under or (over) accrual (line 2 minus line 1).		$ (403)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 54,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 54,397	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	51,459	8
	1998	52,881	9
	1999	51,569	10
	2000	53,167	11
	2001	54,297	12

2000Taxes Paid	$53,167
2001 Taxes Paid	$54,297
% Increase	1.02%
Real Estate tax accrual	$54,839 use 54,800

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Arbor COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0019471

CONTACT PERSON REGARDING THIS REPORT John Florina, Jr.

TELEPHONE (630) 773-9416 FAX #: (630) 773-9434

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-17-102-040	Nursing Home	$ 1,584.00	$ 1,584.00
2.	03-17-102-041	Nursing Home	$ 26,054.00	$ 26,054.00
3.	03-17-102-045	Nursing Home	$ 26,659.00	$ 26,659.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,297.00	$ 54,297.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,391 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	41,000	1975	$ 9,559	1
2	Patient Care	44,336	1992	10,446	2
3	TOTALS	85,336		$ 20,005	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	68		1975	1975	$ 271,012	$	40	$ 6,775	$ 6,775	$ 186,622	4
5			1975	1975	187,817		25			187,817	5
6			1975	1975	113,922		20			113,922	6
7			1975	1975	20,747		10			20,747	7
8	76		1993	1993	2,533,506		40	62,937	62,937	614,044	8
	Improvement Type**										
9	Building Improvements			1976	7,019		25			7,019	9
10	Building Improvements			1976	10,352		40	259	259	6,858	10
11	Building Improvements			1976	2,620		36	73	73	1,715	11
12	Building Improvements			1976	243		10			243	12
13	Building Improvements			1976	608		4			608	13
14	Building Improvements			1987	5,847		20			5,847	14
15	Building Improvements			1988	32,894		35	940	940	13,316	15
16	Building Improvements			1991	32,267		35	922	922	10,603	16
17	Building Improvements			1993	168,024		40	4,201	4,201	39,907	17
18	Building Improvements			1993	21,405		40	535	535	5,075	18
19	Building Improvements			1987	12,923	410	35	369	(41)	5,724	19
20	Building Improvements			1988	6,270	199	35	179	(20)	2,686	20
21	Building Improvements			1990	21,197	674	35	605	(69)	7,573	21
22	Building Improvements			1991	986	31	35	28	(3)	323	22
23	Building Improvements			1992	7,503	238	35	214	(24)	2,248	23
24	Building Improvements			1993	12,681	325	40	317	(8)	3,012	24
25	Building Improvements			1994	3,100	79	40	78	(1)	660	25
26	Building Improvements			1994	11,175	287	40	279	(8)	2,373	26
27	Building Improvements			1995	15,605		10	1,561	1,561	11,315	27
28	Cabinets			1996	2,768	89	31	89		579	28
29	Electrical Fixtures			1996	4,972	160	31	160		1,000	29
30	Cabinets			1996	3,097	100	31	100		608	30
31	Building Improvements			1984	12,774		10			12,774	31
32	Building Improvements			1985	7,314		10			7,314	32
33	Building Improvements			1986	4,044		8			4,044	33
34	Building Improvements			1986	1,379		8			1,379	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Front Door Security System	1997	$ 6,230	$ 201	31	$ 201	$	$ 1,105	37
38	Concrete Pads for Washers	1997	4,430	143	31	143		774	38
39	Carpeting	1997	7,271	235	31	235		1,194	39
40	Complete Communications-Nurse Calling Systen	1998	4,543	147	31	147		625	40
41	New Door Opening	1999	1,798	58	31	58		227	41
42	Window Replacement	2000	4,801	155	31	155		323	42
43	Roof	2001	3,665	118	31	118		197	43
44	Hot Water Heater	2001	2,891	93	31	93		147	44
45	Hot Water Heater	2002	885	26	31	26		26	45
46	Landscape Improvements (sidewalks/walkways)	2002	925	12	31	12		12	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,573,510	$ 3,780		$ 81,809	$ 78,029	$ 1,282,585	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 462,544	$ 16,666	$ 48,109	$ 31,443	5-10 years	$ 359,325	71
72	Current Year Purchases	8,071	196	612	416	5-7 years	612	72
73	Fully Depreciated Assets	159,472				5-10 years	159,472	73
74								74
75	TOTALS	$ 630,087	$ 16,862	$ 48,721	$ 31,859		$ 519,409	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2001 Chevrolet Bus	2001	$ 46,219	$	$ 9,244	$ 9,244	5	$ 13,866	76
77										77
78										78
79										79
80	TOTALS			$ 46,219	$	$ 9,244	$ 9,244		$ 13,866	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,269,821	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 20,642	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 139,774	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 119,132	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,815,860	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Itasca Shelter Care, L.L.C. - See Page 6

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ None Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Patient Care	2002 Suburban	$ 662.04	$ 6,620	17
18	Administrative	1999 Seville	673.84	1,348	18
19					19
20					20
21	TOTAL		$ #######	$ 7,968	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	2,148	$ 29,469	$	2,148	$ 29,469	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		89	1,451		89	1,451	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		2,785	41,376		2,785	41,376	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				33,661		33,661	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	5,022	$ 72,296	$ 33,661	5,022	$ 105,957	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (100,648)	$ 188,592	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 60,000)	1,147,371	1,147,371	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	71,595	71,595	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrows & Repl. Reserve		281,287	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,118,318	$ 1,688,845	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,005	13
14	Buildings, at Historical Cost		3,039,771	14
15	Leasehold Improvements, at Historical Cost	124,801	533,739	15
16	Equipment, at Historical Cost	342,582	676,306	16
17	Accumulated Depreciation (book methods)	(329,397)	(1,815,860)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify (Mtg. Costs)		194,264	22
23	Other(specify): Deferred costs- Apts		1,272	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 137,986	$ 2,649,497	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,256,304	$ 4,338,342	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 123,069	$ 123,069	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	42,500	42,500	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	126,790	126,790	30
31	Accrued Taxes Payable (excluding real estate taxes)	881	881	31
32	Accrued Real Estate Taxes(Sch.IX-B)		54,800	32
33	Accrued Interest Payable	82	34,309	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 293,322	$ 382,349	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	485,000	485,000	39
40	Mortgage Payable		5,008,760	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 485,000	$ 5,493,760	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 778,322	$ 5,876,109	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 477,982	$ (1,537,767)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,256,304	$ 4,338,342	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 605,583	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 605,583	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(127,601)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (127,601)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 477,982	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,353,348	1
2	Discounts and Allowances for all Levels	(131,388)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,221,960	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	118,259	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 118,259	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	10,659	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	38,175	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	66,386	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 115,220	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	141	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 141	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous Income (offset against expense)**	6,355	28
28a	**Vending Machine Income (offset against expense)**	5,893	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,248	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,467,828	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	877,791	31
32	Health Care	2,600,475	32
33	General Administration	874,245	33
	B. Capital Expense		
34	Ownership	1,107,868	34
	C. Ancillary Expense		
35	Special Cost Centers	56,210	35
36	Provider Participation Fee	78,840	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,595,429	40
41	**Income before Income Taxes (line 30 minus line 40)****	(127,601)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (127,601)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,027	2,064	$ 64,861	$ 31.42	1
2	Assistant Director of Nursing	2,145	2,008	55,545	27.66	2
3	Registered Nurses	15,419	15,442	361,827	23.43	3
4	Licensed Practical Nurses	17,013	17,282	392,174	22.69	4
5	Nurse Aides & Orderlies	74,591	74,743	1,030,250	13.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,986	2,056	33,820	16.45	9
10	Activity Assistants	7,395	7,483	74,798	10.00	10
11	Social Service Workers	2,035	2,024	39,520	19.53	11
12	Dietician					12
13	Food Service Supervisor	2,276	2,032	40,780	20.07	13
14	Head Cook	6,197	6,197	76,745	12.38	14
15	Cook Helpers/Assistants	14,501	14,501	131,164	9.05	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,304	2,080	74,863	35.99	20
21	Assistant Administrator	2,093	1,960	76,404	38.98	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,630	6,817	110,729	16.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca: Ward Clerks	4,047	4,055	28,179	6.95	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,659	160,744	$ 2,591,659 *	$ 16.12	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	195	$ 7,777	L1, C3	35
36	Medical Director	150	4,950	L9, C3	36
37	Medical Records Consultant	18	900	L10, C3	37
38	Nurse Consultant	7	385	L10, C3	38
39	Pharmacist Consultant	Monthly	995	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	520	L11, C3	44
45	Social Service Consultant	53	2,888	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	433	$ 18,415		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,363	$ 59,063	L10, C3	50
51	Licensed Practical Nurses	5,966	222,325	L10, C3	51
52	Nurse Aides	1,144	27,385	L10, C3	52
53	TOTAL (lines 50 - 52)	8,473	$ 308,773		53

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Florina Jr	Admin/Asst. Admin	10.00%	$ 109,100
Thomas Annarella	Asst. Admin/Admin	0%	42,167
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 151,267

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
American Express Tax &		$
Business Services	Accounting	7,442
Achieve Software	Computer services	12,047
Altschuler Melvoin & Glasser	Accounting	25,000
Porte Brown LLC	Accounting	6,085
Personnel Planners	U/C Consulting	723
Stratton, Stone & Kopec	Legal	1,156
Accurate Computer Services	Computer services	300
Ivans	Computer services	286
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 53,039

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 58,203
Unemployment Compensation Insurance	12,531
FICA Taxes	196,416
Employee Health Insurance	64,651
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other employee benefits	10,278
TOTAL (agree to Schedule V, line 22, col.8)	$ 342,079

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	5,026
Health Care Worker Background Check	
(Indicate # of checks performed 26)	562
Illinois Health Care Association Dues	7,613
Miscellaneous Subscriptions	1,082
Miscellaneous Dues	861
Miscellaneous Licenses	768
Miscellaneous Permits	600
Miscellaneous Inspections	4,748
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,260

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,421
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,421

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

The Arbor
Provider #: 0019471
01/01/02 to 12/31/02

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)		$ 53,039
Nonallowable legal fees:		
Stratton, Stone & Kopec - out of period expenses.	Legal	$ (238)
Total (agree to Schedule V, line 19, column 8)		$ 52,801

See Accountants' Compilation Report

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Re-decorating Facility	Feb 99	$ 4,182	3	$ 697	$ 1,394	$ 1,394	$ 697	$	$	$	$	$
2	Re-decorating Facility	June 99	2,484	3	414	828	828	414					
3	Air Conditioning Units	July 99	3,817	3	636	1,272	1,272	637					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 10,483		$ 1,747	$ 3,494	$ 3,494	$ 1,748	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $7,613**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **69,440** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **78,840**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **The Arbor** **02:08 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-476,095	equal to	-476,095	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	419,940	equal to	419,940	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	54,397	equal to	54,397	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	139,774	equal to	139,774	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	7,968	equal to	7,968	0	FAILED	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	72,296	equal to	72,296	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	33,661	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	877,791	equal to	877,791	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,600,475	equal to	2,600,475	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	874,245	equal to	874,245	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,107,868	equal to	1,107,868	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	56,210	equal to	56,210	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	78,840	equal to	78,840	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,904,657	equal to	1,932,836	-28,179	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	108,618	equal to	108,618	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	39,520	equal to	39,520	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	248,689	equal to	248,689	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	0	equal to		0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	0	equal to		0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	151,267	equal to	151,267	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	110,729	equal to	110,729	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,591,659	equal to	2,591,659	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	7,777	< or = to	7,777	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	4,950	< or = to	4,950	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	311,053	< or = to	311,053	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	520	< or = to	520	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,888	< or = to	2,888	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	151,267	equal to	151,267	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	53,039	equal to	53,039	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	342,079	equal to	342,079	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	21,260	equal to	21,260	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,421	equal to	1,421	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	78,840	equal to	78,840	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	N/A	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	N/A	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,395	equal to	1,395	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-464,808	equal to	-464,808	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	5,493,760	equal to	5,493,760	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	54,800	equal to	54,800	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	20,005	equal to	20,005	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,573,510	equal to	3,573,510	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	676,306	equal to	676,306	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,815,860	equal to	1,815,860	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	477,982	equal to	477,982	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-127,601	equal to	-127,601	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,256,304	equal to	1,256,304	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	248,689	30,947	7,777	287,413	0	287,413	0	287,413
2. Food P	0	197,591	0	197,591	0	197,591	0	197,591
3. Housek	0	26,190	244,305	270,495	0	270,495	0	270,495
4. Laundry	0	6,625	0	6,625	0	6,625	0	6,625
5. Heat ar	0	0	87,694	87,694	0	87,694	0	87,694
6. Mainter	0	10,567	17,406	27,973	0	27,973	1,748	29,721
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	248,689	271,920	357,182	877,791	0	877,791	1,748	879,539
9. Medical	0	0	4,950	4,950	0	4,950	0	4,950
10. Nursin	1,932,836	124,094	311,053	2,367,983	0	2,367,983	0	2,367,983
10a. Ther	0	0	72,296	72,296	0	72,296	0	72,296
11. Activit	108,618	3,700	520	112,838	0	112,838	0	112,838
12. Social	39,520	0	2,888	42,408	0	42,408	0	42,408
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	2,080,974	127,794	391,707	2,600,475	0	2,600,475	0	2,600,475
17. Admin	151,267	0	0	151,267	0	151,267	0	151,267
18. Direct	0	0	30,000	30,000	0	30,000	0	30,000
19. Profes	0	0	53,039	53,039	0	53,039	-238	52,801
20. Fees,	0	0	22,801	22,801	0	22,801	-1,541	21,260
21. Clerica	110,729	25,665	27,368	163,762	0	163,762	-3,491	160,271
22. Emplo	0	0	342,079	342,079	0	342,079	0	342,079
23. Inserv	0	0	2,292	2,292	0	2,292	0	2,292
24. Travel	0	0	1,421	1,421	0	1,421	0	1,421
25. Other	0	0	0	0	0	0	0	0
26. Insura	0	0	107,584	107,584	0	107,584	0	107,584
27. Other	0	0	0	0	0	0	0	0
28. Total (	261,996	25,665	586,584	874,245	0	874,245	-5,270	868,975
29. Total (	2,591,659	425,379	1,335,473	4,352,511	0	4,352,511	-3,522	4,348,989
30. Depre	0	0	20,642	20,642	0	20,642	119,132	139,774
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	4,778	4,778	0	4,778	415,162	419,940
33. Real E	0	0	0	0	0	0	54,397	54,397
34. Rent -	0	0	1,074,480	1,074,480	0	1,074,480	########	0
35. Rent -	0	0	7,968	7,968	0	7,968	0	7,968
36. Other	0	0	0	0	0	0	26,623	26,623
37. Total (	0	0	1,107,868	1,107,868	0	1,107,868	-459,166	648,702
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	33,661	0	33,661	0	33,661	0	33,661
40. Barbe	0	0	9,142	9,142	0	9,142	0	9,142
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	78,840	78,840	0	78,840	0	78,840
43. Other	0	0	13,407	13,407	0	13,407	-13,407	0
44. Total S	0	33,661	101,389	135,050	0	135,050	-13,407	121,643
45. Grand	2,591,659	459,040	2,544,730	5,595,429	0	5,595,429	-476,095	5,119,334

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	-100,648	188,592
2. Cash - F	0	0
3. Account	1,147,371	1,147,371
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	71,595	71,595
7. Other Pr	0	0
8. Account	0	0
9. Other (s	0	281,287
10. Total c	1,118,318	1,688,845
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	0	20,005
14. Buildin	0	3,039,771
15. Leaseh	124,801	533,739
16. Equipn	342,582	676,306
17. Accum	-329,397	########
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other l	0	194,264
23. other (s	0	1,272
24. Total L	137,986	2,649,497
25. Total A	1,256,304	4,338,342
CURRENT LIABILITIES		
26. Accour	123,069	123,069
27. Officer'	0	0
28. Accour	42,500	42,500
29. Short-T	0	0
30. Accrue	126,790	126,790
31. Accrue	881	881
32. Accrue	0	54,800
33. Accrue	82	34,309
34. Deferre	0	0
35. Federa	0	0
36. Other (	0	0
37. Other (	0	0
38. Total C	293,322	382,349
LONG TERM LIABILITES		
39.Long-Te	485,000	485,000
40.Mortgag	0	5,008,760
41.Bonds I	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	485,000	5,493,760
46.Total Li	778,322	5,876,109
47.Total Eq	477,983	########
48.Total Li	1,256,305	4,338,342

		Balance per Medicaid Trial Balance
1.	Gross F	5,353,348
2.	Discour	-131,388
	Subtota	5,221,960
4.	Day Ca	0
5.	Other C	0
6.	Therapy	118,259
7.	Oxygen	0
	Subtota	118,259
9.	Paymer	0
10.	Other	0
11.	Nurses	0
12.	Gift an	0
13.	Barber	10,659
14.	Non-P	0
15.	Teleph	0
16.	Rental	0
17.	Sale o	38,175
18.	Sale o	0
19.	Labora	0
20.	Radiol	0
21.	Other	66,386
22.	Laund	0
	Subtot	115,220
24.	Contril	0
25.	Interes	141
	Subtot	141
27.	Other	6,355
28.	Other	5,893
	Subtot	12,248
30.	Total F	5,467,828
31.	Gener	680,120
32.	Health	1,154,988
33.	Gener	668,561
34.	Owner	144,710
35.	Specia	60,174
35.	Provid	41,063
37.	Other	0
40.	Total E	2,749,616
41.	Incom	2,718,212
42.	Incom	0
43.	Net In	2,718,212

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Line 16 for mortgage insurance.